

Surgical Information

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OPERATION REPORT

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STANDARD TITLE: OPERATIVE REPORT
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URGENCY: STATUS: COMPLETED
SUBJECT: Case #: 248913

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* medical record should be reviewed to ensure that all information *
* concerning this event has been reviewed or noted. *

NAME OF PATIENT: JOHNSON, MAURICE
SOCIAL SECURITY #: [REDACTED]
DATE OF SURGERY: 07/15/2002
WARD NO:
CASE NO: 248913

ATTENDING PHYSICIAN: QUERAL, LUIS
ASSISTANT:
FIRST ASSISTANT: BOATENG, PERCY
SERVICE:

PREOPERATIVE DIAGNOSIS: Acute aortic occlusion with embolization to the left popliteal artery.

OPERATIONS PERFORMED:
1. Aortobifemoral thrombectomy.
2. Left popliteal thrombectomy.

ANESTHESIA: General.

INDICATIONS FOR OPERATION: Mr. Johnson is a 54-year-old man who presented to the Vascular Service with acute onset of left leg pain with associated left foot numbness and coolness for approximately four days. His evaluation included noninvasive studies, which showed the left ABI at 0.19 and the right ABI of 0.54. His toe pressure on the left was 0 and his toe pressure on the right was 0.35. He underwent an angiogram, which showed an aortic occlusion in the infrarenal portion with reconstitution of the left distal external iliac artery to the left popliteal artery where it re-occluded with an abrupt cutoff indicating possible embolic

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phenomenon. He had a reconstitution of the right SFA without significant flow to the right lower extremity. The patient underwent a necessary preoperative medical workup including carotid studies and a medical pre-evaluation and he was deemed a safe candidate for aortobifemoral reconstruction. The risks and benefits were discussed with the patient. Informed consent was obtained and the patient was brought to the operating room on the day of surgery for the above procedure.

OPERATION: The patient was placed in the supine position. General anesthesia was induced and endotracheal tube was placed without incident. The abdomen and bilateral groins were prepped in a sterile fashion. This was draped sterily and an Ioban dressing placed on entire surgical field. A midline incision was made from the xiphoid process to the pubis sharply through the skin. This was carried through the subcutaneous tissues to the fascia entering the abdomen transperitoneally without incident. The abdomen was explored and found to be without significant pathology. Following this, the Balfour retractor was placed and the small bowel tacked along the right gutter. The colon and omentum were packed cephalad and using additional handheld retractors, the said exposure of the surgical field was obtained. The duodenum was then reflected off the aorta sharply. Next, we incised the retroperitoneal covering overlying the aorta. Exposing the portion of the aorta just inferior to the point of the crossing of the left renal vein, the dissection was carried around the aorta in a circumferential fashion using a combination of sharp dissection and blunt dissection until the aorta was completely dissected free of its connective tissue covering in a circumferential fashion. After dissection of an area around the aorta, an aortic clamp was passed around the dissected section. This was found to pass freely around the aorta without any difficulty. A red rubber catheter was passed around the aorta, clamped, and protected from the surgical field.

Next, we turned our attention to the groins. Bilateral groin incisions were made over the femoral artery. This was carried through the subcutaneous tissues with a combination of electrocautery and sharp dissection until the SFA was identified. Using further sharp dissection in a cephalad fashion, the common femoral artery was dissected out and next we dissected out the profunda vessels. The vessel loops were passed around all of its arterial branches and the groin incisions were then covered with antibiotic-soaked Ray-Tec sponges.

Next, we turned our attention to create retroperitoneal tunnels for passage of the graft limbs. The retroperitoneum along the course of the external iliac and the common iliac arteries were incised under the abdomen, and using blunt dissection, in an antegrade and retrograde fashion, retrograde femoral-femoral incisions, the retroperitoneal tunnel along the course of the common iliac, external iliac, and the femoral artery were created with the tunnel dissecting through all incisions

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bilaterally. The ureters were identified and protected all through this dissection. Following the dissection, Silastic tube was placed through the tunnels bilaterally to later facilitate passage of the graft. Following creation of the tunnel, the patient was given 5000 units of heparin. After allowing sufficient time for the heparin to circulate, we then proceeded to clamping of the aorta in the area of dissection just distal to the renal vein. Using the red rubber catheter that had been passed previously as a guide, an aortic clamp was passed behind the aorta completely encircling the aorta. This area was then clamped. A transverse arteriotomy below the point of clamping was then made about half way across the diameter of the aorta. Upon making an incision, we noted medially that there was a large amount of plaque seen in the area of arteriotomy indicating occlusion of aorta proximally and distally from our clamp site. Guess with this, decision was made then to completely transect the aorta. This was done and the distal aorta was then oversewn with #3-0 Prolene suture in a running fashion. Following oversewing of the aorta, we then proceeded to extract the thrombus in the proximal portion of the aorta. Forceps was used to grab the thrombus and clamp and aligned from the aorta to dislodge the clot. The clot was then pulled out and large thrombus was extracted from the aorta. Also noted after extraction of the thrombus was a significant amount of atherosclerotic plaque in the area where the thrombus was previously. The thrombus was inspected for a meniscus. One was found indicating a complete extraction of the thrombus. Following extraction of the thrombus, the aorta was temporarily unclamped to ensure unobstructed antegrade flow. This was found to be adequate. Following this, we then proceeded to perform our anastomosis. Using 18 x 9 Hemashield graft, the tube portion was sewn to the aorta in an end-to-end fashion using a running #3-0 Prolene. After completion of the suture line, the distal portion of the graft just prior to the takeoff of the limbs was clamped and next we unclamped the aorta just proximal to our anastomosis and inspected the suture line for hemostasis. This was found to be adequate. Please note that all of the atherosclerotic plaque that was noted previously, especially the thrombus had been debrided prior to performing anastomosis after completion of anastomosis and clamping as above.

Next, we turned our attention to tunneling the graft to the retroperitoneal tunnels. Using the Silastic tube as a guide, Charnley clamps were then passed through our retroperitoneal tunnels from the groins into the abdomen. The graft limbs were then grabbed in sequence and passed out to exit out of our groin incisions bilaterally. Prior to passage of the graft, the graft limbs had been flushed in an antegrade fashion and then reclamped in the tubular portion just prior to the takeoff of the wide limbs. First, we performed an arteriotomy over the left common femoral artery. After vascular clamps had been placed on the distal SFA, the common femoral, and the profunda controlled with the vessel loop, the SFA was checked for retrograde flow. There was some

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flow, but this was minimal. We then proceeded to perform anastomosis in an end-to-side fashion after shortening of the graft limb to provide a tension-free anastomosis and to make sure there was not any slack in the length of the graft in the tunnel. An end-to-side anastomosis was performed using #5-0 Prolene in a running fashion. After completion of anastomosis, the right limb of the graft was then clamped. Following this, the proximal clamp on the tube part of on the graft was removed allowing antegrade flow to the left limb of the graft. This suture line was inspected for adequate hemostasis. This was found to be good and after a few cardiac cycles, the clamp in the right limb of the graft was taken off allowing flushing of the graft once more through the right limb of the graft. Following this, this was clamped again. Then, the vessel loop of the profunda was released followed by the release of the common femoral clamp and then lastly the clamp of the SFA taken off. The distal SFA was checked for pulse and this was found to be present.

Following this, we turned our attention to the right groin. The SFA and the common femoral were then controlled with vessel clamp and the profunda controlled with vessel loop. After this, a longitudinal arteriotomy was performed. The graft limb was cut to appropriate length again ensuring that, that was taut in this tunnel. We then proceeded to perform an end-to-side anastomosis using a #5-0 Prolene suture in a running fashion. Following completion of anastomosis with the vessel clamp still in place and control of the common femoral artery, profunda, and SFA, the right limb grasp clamp was released allowing antegrade flow towards anastomosis. Anastomosis was inspected for hemostasis and this was found to be good.

Next, the vessel clamps were removed by first unclamping the common femoral artery, then the profunda, and lastly the SFA. After completion of groin anastomosis, we then turned our attention back to the abdomen and inspected our aortic anastomosis for hemostasis. This was found to be good. All areas of surgical dissections were inspected for anastomosis. Small bleeding points were controlled with electrocautery. Then, after hemostasis was deemed satisfactory, we proceeded to close the retroperitoneum over our graft using a #3-0 Vicryl suture in a running fashion. After closure of the retroperitoneum over the aortic graft, the abdomen was inspected once more for hemostasis. This was found to be satisfactory. The ureters were identified and found to be intact without any evidence of injury.

We next proceeded to close the abdomen using #2-0 nylon in a running fashion. The fascia was approximated using #2 nylon in a running fashion. Following this, the skin was approximated using staples. After closure of the abdomen, we next turned our attention back to the groin.

Because of the angiographic findings of a possible embolus to his left popliteal artery, we performed a embolectomy of the left popliteal

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artery. The proximal SFA just distal to our anastomosis was clamped with a vessel clamp and at a point further distal, an SFA was chosen and this was controlled with a vessel loop. A transverse arteriotomy was performed. A Fogarty catheter was then passed distally and then withdrawn. There was a fair amount of thrombus that was extracted with the passage of the embolectomy catheter. This thrombus was suspected for a meniscus and the one was found indicating complete embolectomy of the artery. The backflow from the artery was checked and this was found to be vigorous also indicating that all of the thrombus had been extracted. No further debris was noted to backflow into the artery through our arteriotomy site. The arteriotomy incision was then closed using a running #5-0 Prolene suture. The vascular clamps were removed and then the groin incision anastomosis was inspected for hemostasis. A Gelfoam thrombin was used to aid in anastomosis. This was found to be adequate.

The groin incisions were then closed in a two-layer fashion, first using #3-0 Vicryl in the deep layer and then a next superficial layer again with a running #3-0 Vicryl. Following this, the groin incisions were then stapled bilaterally. Sterile dressings were placed in the abdominal incision and groin incisions. The patient was awakened from anesthesia without incident, successfully extubated, transported to the ICU. Sponge and needle counts were correct. He tolerated the procedure well and he was noted to have palpable distal pulses bilaterally.

After closure of the retroperitoneum, the bowel was inspected and found to be viable.

PERCY BOATENG
DICTATING PHYSICIAN

LUIS QUERAL
ATTENDING PHYSICIAN

DD: 07/18/2002
DT: 07/19/2002
INFOPRO /JOB#751906

NURSE INTRAOPERATIVE REPORT

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